



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Emergency Department Quality of Care, Safety, and Management Issues

Dallas VA Medical Center Dallas, Texas

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations concerning quality of care, safety, and management issues in the Emergency Department (ED) at the Dallas VA Medical Center (the facility), Dallas, TX.

We concluded that four patients identified in allegations to the OIG had received appropriate care. Because both managers and staff identified timely response by the Orthopedic Surgery Service as an ongoing concern, we recommended that facility managers monitor timeliness of orthopedic consultations and take actions to ensure timely response for all ED patients.

We did not substantiate allegations of inadequate ED staffing and inappropriate scheduling of physicians, or of excessive verbal and physical assaults on staff with a lack of VA police intervention. However, we received complaints related to poor communication and the lack of teamwork in the ED. We recommended that managers and staff should undergo training to help foster a work environment in the ED that encourages open communication, cooperation, and respect.

We did not substantiate allegations of excessive paperwork for inter-facility transfers or inappropriate physician assistance to the remote community living center and clinics. However, we identified an improvement opportunity with the inter-facility transfer process.

We recommended that the Facility Director ensure that:

- Registered nurse triage practices are consistently performed and that training is completed.
- Communication and referral processes between the ED and primary care clinics include more effective data sharing and joint efforts to improve patient flow.
- ED managers monitor orthopedic surgery timeliness of response to ED consultation requests.
- ED managers and staff undergo training that would help promote a positive work environment in the ED.
- The current inter-facility transfer process is assessed and appropriate administrative support is provided for paperwork requirements.

The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Heart of Texas Health Care Network (10N17)

SUBJECT: Healthcare Inspection – Emergency Department Quality of Care, Safety, and Management Issues, Dallas VA Medical Center, Dallas, Texas – Project Number: 2011-02051-HI-0138

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation to determine the validity of allegations concerning quality of care, patient and staff safety, and management issues in the Emergency Department (ED) at the Dallas VA Medical Center (the facility), Dallas, TX.

Background

VHA ED Policy: EDs provide emergent care to all who present in need of such care. This includes initial evaluation, treatment, and disposition for a broad spectrum of illnesses, injuries, and psychiatric disorders, as well as resuscitative therapy and stabilization in life-threatening situations.¹ VHA requires registered nurse (RN) triage in all EDs and the use of the Emergency Severity Index (ESI)² as the sole triage tool. The ESI triage algorithm yields rapid and clinically relevant stratification of patients presenting for ED care and provides a method for categorizing patients by both acuity and resource needs.³

The ED also provides emergent mental health (MH) services to patients seeking or requiring acute psychiatric care, and approximately 50 percent of behavioral emergencies requiring acute intervention in hospitals occur in the ED and urgent care centers. Facility police must be available when requested to provide standby assistance or intervention for the management of any patient who presents a danger to himself/herself or others, who is potentially violent, or who exhibits violent or agitated, unpredictable behavior.⁴

¹ Veterans Health Administration (VHA) Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010.

² A 5-level ED triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent).

³ VHA Handbook 1101.05.

⁴ VHA Directive 2010-008, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.

In 2008, VHA implemented the ED Integration Software (EDIS) which offers an open-view digital log of critical activities in the ED. It produces a centrally located display of all active patients in the ED as well as their location, status, and provider. EDIS updates and replaces the manual white board still found in many EDs. It incorporates several web-based views that help staff track and manage patient flow and patient care.⁵ The deadline for implementation of EDIS at all VHA EDs was July 31, 2011.⁶

The practice of VHA emergency medicine also includes support and participation in the existing Emergency Medical System (EMS)⁷ and the provision of medical direction for patients in the pre-hospital setting. The scope of services includes administrative involvement in hospitals and outpatient facilities, and emergent care that is congruent with the facility's capabilities, in and around all medical centers, community based outpatient clinics, domiciliaries, and administrative offices.⁸

Allegations: In March 2011, a complainant contacted OIG's Hotline Division and alleged that the closure of the "fast track" (treat less acute patients) section of the ED resulted in quality of care and safety concerns in the ED. In addition, the complainant alleged inefficient and inappropriate ED management practices.

Quality of care issues:

1. Delayed admission of an identified ventilator patient (Patient 1).
2. Inadequate patient triage and inappropriate physician assignment of patients.
3. Poor communication and inappropriate referrals between the ED and primary care clinics (PCCs) (Patients 2 and 3).
4. Poor response to ED consultation requests made to orthopedic surgery, gynecology, and trauma surgery specialists (Patient 4).

Safety issues:

1. Inadequate physician staffing and inappropriate scheduling.
2. Excessive verbal and physical assaults on staff with lack of intervention by VA police.

ED management concerns:

1. Excessive paperwork required of physicians.
2. Inappropriate ED physician assistance to the remote Community Living Center (CLC) and clinics.

Facility ED: With 544 hospital beds, the facility is the referral center for the VA North Texas Health Care System (the system) which includes eight outpatient clinics and the

⁵ VHA, *Introductory Training to EDIS*, October 2008.

⁶ VHA, *Monograph Details – Emergency Department Integration Software (EDIS)*, October 15, 2010.

⁷ Type of emergency service that provides out-of-hospital acute medical care and transport to definitive care to patients with illnesses and injuries which the patient, or the medical practitioner, believes constitutes a medical emergency.

⁸ VHA Handbook 1101.05.

Sam Rayburn Memorial Veterans Center in Bonham, TX. The Bonham facility (located 80 miles away from the facility) has 136 CLC and 229 MH residential rehabilitation treatment program beds. The system is a part of the Veterans Integrated Service Network (VISN) 17 and provides tertiary care to veterans in 40 counties in northern Texas and southern Oklahoma.

Emergency/urgent care at the facility, before May 2010, was delivered in two separate physical sections of the ED. The “major” side (main ED) has 13 beds and is for patients deemed to require emergent care (ESI 1, 2, and 3). The “minor side” or “fast track” has four examination rooms for less acute patients (ESI 4 and 5).

Beginning in May 2010, the ED underwent reorganization that included transitioning from an independent service line to a clinical section under the Medicine Service and appointment of a new ED Director. Also during May 2010, the facility began implementing the EDIS system to track patient flow in the ED.

Prior to March 2011, the minor section of the ED was staffed with two physicians and a physician assistant (PA). However, when the PA transferred to another clinic, facility leadership and ED managers made the decision to consolidate this section and merged its workload, including physician staffing, with the main ED. Facility leaders eliminated the previous practice of assigning two physicians to manage minor cases only.

To facilitate timely care for all ED patients, facility managers changed procedures to improve operations and instructed ED nurses to assign patients to the ED physicians on duty to ensure equal distribution of workload. Facility leaders reiterated that the fast track section did not close. Instead, it was renamed as the “minor side” of the ED. They also stated that this name change was long overdue because “fast track” gave a false impression regarding the timeliness of care.

The facility also granted ED staff physicians the authority to admit to all inpatient services and subspecialties except mental health.⁹ Potential receiving services are expected to respond to ED consultation requests for examination of patients to assist in the determination of medical and ongoing treatment needs. Patients with emergent needs are admitted immediately. Established procedures are in place for pediatric, gynecologic, and trauma cases which exceed the capacity of either the ED or the facility. Once deemed stable, the facility transfers these patients to a local hospital capable of providing the required specialty care.¹⁰

While facility leaders acknowledged that these changes have caused divisiveness in the section and that some staff continue to undermine improvement efforts, they believe that changes in ED leadership and operations were necessary to address patient flow,

⁹ VA North Texas Healthcare System (VANTHCS) Memorandum 139-01, *Admission Policy*, February 2, 2010.

¹⁰ Facility Memorandum 111-02, *Provision of Emergency Services*, September 1, 2009.

productivity, and staffing issues. Managers determined that these changes would make staff more accountable and productive.

Scope and Methodology

We visited the facility May 11–12, 2011. We reviewed VHA and facility policies and procedures, medical records, and incident reports. We also reviewed staffing, workload, and performance improvement data; ED transfer reports; and other information related to this case. We toured the ED and interviewed both clinical staff and facility managers.

We conducted this inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Quality of Care

Delayed Admission of Ventilator Patient

We did not substantiate the allegation of delayed admission of a ventilator patient. The patient required emergent intervention in the ED. Appropriate communication and collaboration occurred between the ED and intensive care unit (ICU) physicians. ICU physicians provided prompt evaluation and treatment, and admission to the medical ICU (MICU) was facilitated in a timely manner.

Case Review Patient 1. The patient, a male veteran in his late 40's with a history of hypertension and obesity, presented to the ED in acute respiratory distress. He was triaged with an ESI score of 1 with inspiratory stridor¹¹ and poor oxygenation. The ED team inserted a breathing tube and placed the patient on mechanical ventilation within 30 minutes of initiation of ED care. ICU residents evaluated the patient within 30 minutes of intubation and accepted the patient for admission to the MICU. The patient arrived to the MICU an hour later.

Inadequate Patient Triage and Inappropriate Assignment of Patients

We substantiated the allegation that RN triage practices were inadequate and noted that training efforts to improve performance in this area were already underway. However, we did not substantiate that patient assignments to ED physicians were inappropriate.

When clarifying the allegation of inadequate patient triage practices, the complainant stated that ED RNs triage patients in a “haphazard manner” and questioned the RNs assignments of specific patients to the ED physicians on duty.

¹¹ A wheezing sound when inhaling, indicative of a medical emergency.

During our onsite evaluation, we found that ED RNs consistently used ESI triage algorithms to stratify patients presenting for ED care. However, the ED nurse manager stated that a recent competency assessment of nursing triage skills revealed deficiencies. Specific RNs are currently undergoing training to ensure consistent triage skills with existing triage protocols.

Additionally, ED managers had instructed the RNs in a system for assigning patients to the ED physicians on duty. After triaging and determining the ESI of each patient and reviewing physician workload and availability, the RNs entered patient assignments for the ED physicians into the EDIS system. The goal was to facilitate timely care and workload equity.

Poor Communication and Inappropriate Referrals to the ED

We substantiated the allegation that communication and referral processes between the ED and PCCs needed improvement. We found that more effective data sharing, and joint efforts to address patient flow concerns between these departments, was needed.

VHA policy requires that the ED team establish effective working relationships with other providers and entities with whom they must interact.¹² One reason this is necessary is if required care is not emergent or urgent, facility policy states that outpatients without appointments are to be directed to their assigned clinic for evaluation.¹³

During our onsite interviews, we noted a lack of effective communication and collaboration between the ED and the PCCs in addressing unscheduled patient visits. Two patient referrals specifically identified by the complainant were evaluated as noted below.

Case Review Patient 2. In the late morning hours, a patient in his early 60's presented to the ED requesting removal of a suture in the back of his head. The suture was apparently left in place from a minor surgical procedure that took place 10 months prior. An ED nurse triaged the patient with an ESI score of 5. An ED physician removed the suture and noted no drainage or evidence of infection. He discharged the patient home with instructions to return to the ED if there were any further concerns. The patient was also to follow up with his primary care physician the following week.

Case Review Patient 3. A patient in his mid-50's presented to the PCC at approximately 3:20 p.m. with complaints of toe pain. The PCC physician examined him an hour later and documented the potential presence of a splinter. The physician ordered an immediate foot x-ray and referred the patient to the ED for further care. Upon arrival to the ED, the RN noted the patient's toe pain and triaged the patient with an ESI score of 4. The

¹² VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010.

¹³ Facility Memorandum 11C-01, *Outpatient Care and Services*, March 1, 2010.

physician removed the splinter with a needle for this “minor” care patient. He discharged the patient home after providing him instructions to see his primary care provider for follow-up care within 3 days.

Both cases indicate inappropriate ED referrals. Facility managers need to take actions to ensure effective communication and appropriate referrals between the ED and PCCs.

Poor Response to ED Consultations

We did not substantiate the allegation of poor response to ED consultation requests by orthopedic surgery for Patient 4 due to conflicting information from the ED and orthopedic providers. However, because both managers and staff have identified timely response by orthopedic surgery as an ongoing concern, we recommended that managers monitor timeliness of orthopedic consultations and take actions as necessary to ensure timely consultation responses for all ED patients. Orthopedics Service has an agreement with primary care; however, there is no such agreement with the ED.

We did not substantiate allegations of poor response by gynecology and trauma surgery specialists. Contractual arrangements with local non-VA facilities are in place for patients with urgent gynecological and major trauma needs.

Routine gynecology care is available at the facility; however, when care is required after hours or for any urgent gynecologic case, ED providers refer patients to the contracted non-VA medical center. ED providers transfer trauma patients to a second contracted facility when they assess patients’ needs to exceed the capabilities of the facility.

Case Review Patient 4. A patient in her mid-40’s presented to the ED with left wrist pain, swelling, and disfigurement after sustaining a standing fall. The ED RN triaged her as an ESI 3. The RN applied ice packs, and an x-ray showed a lower arm fracture. The ED physician assessed the patient to be in stable condition and documented multiple unsuccessful attempts to contact two orthopedic surgeons for consultation over the next 3 hours. However, we found medical record documentation by the two orthopedic surgeons denying the receipt of any pages from the ED regarding this patient.

The ED physician subsequently ordered placement of a splint on the patient’s wrist. The patient was instructed to follow up in the orthopedic surgery clinic the next week and was discharged home. The physician placed an orthopedic surgery consultation request after the patient went home. A facility orthopedic surgeon assessed the patient 3 days later, and successful surgical repair took place 6 days after the initial ED visit.

Issue 2: Patient and Staff Safety

Inadequate Physician Staffing and Scheduling

We did not substantiate the allegation of inadequate ED physician staffing and scheduling. However, during our interviews, we noted concerns about the work environment.

Based on the recommended baseline for physician staffing in the ED (2.0 patients seen and managed per hour)¹⁴ and the daily ED census during February and March 2010, physician staffing was adequate, and contingency staffing plans were in place.

We found that during the course of 30 days in February and March 2011, the ED provided initial evaluation and treatment to 3,481 patients. This ranged from 68 to 147 patients per day. In our review of the acuities of these patients, we found that 53 percent were ESI 4–5 patients, with the daily percentages of these “minor” patients ranging from 37 to 72 percent. A facility audit of patient load in the ED revealed a wide range of productivity among physicians that varied from an average of 9 to 24 patients per physician per shift.

ED managers staffed the department with staggered shifts and instituted creative scheduling with physicians placed in an “on call” status to cover unexpected staffing shortages. Physicians were granted compensatory time if they were “called in.” Days off would be granted when they worked a substantial number of extra hours. Our review of the March 2011 staffing schedule revealed plans with sufficient physician coverage.

During our interviews, the majority of staff described a work environment in the ED that is not conducive to quality patient care, effective teamwork, and excellent customer service. Specifically, staff expressed their belief that there was poor communication and a lack of teamwork between ED managers, physicians, and nursing staff. We determined that facility leaders need to facilitate a more positive working environment in the ED through improved communication and interactions between ED managers, physicians, and nursing staff.

ED Staff Safety

We did not substantiate the presence of excessive verbal and physical assaults on staff with lack of intervention by VA police. The facility had appropriately initiated the presence of VA police in the ED. Actual incidents of workplace violence in the ED have remained low, and the facility managed these incidents appropriately.

During our site visit, we noted that the ED was staffed with a VA police officer from 3:00 p.m. to 7:00 a.m. This practice has been in place since August 24, 2009. Two

¹⁴ VHA Directive 2010-010, Attachment B, *Provider Staffing*, March 2, 2010.

assaults had taken place in the ED during the period of April 1, 2010, to March 31, 2011. One involved an assault by a patient on a nursing employee, and the other involved a domestic violence assault by a patient on his wife while in the ED. VA Police handled the incidents appropriately and submitted regular reports to the facility Disruptive Behavior Committee whose membership includes VA police representation. VA Police also hold security briefings with the ED staff as appropriate.

Issue 3: ED Management Practices

Excessive Paperwork for Physicians with Inter-Facility Transfers

We did not substantiate the allegation of excessive paperwork required of physicians for inter-facility transfers. However, we noted inadequate administrative support for completion of paperwork for transfers out of the facility.

VHA policy requires health care facilities to accomplish all transfers of ED patients to other health care facilities in a manner that ensures maximum patient safety.¹⁵ The policy mandates ED physicians to complete four inter-facility transfer documents for coordination of continued care with receiving health care facilities. In addition, the facility requires ED physicians to complete a “Travel Consult” document and provide copies of four other items (an administrative data sheet, recent history and physical, list of medications, and progress notes) to the transferring facilities. These additional documents could be assigned to clerical or other non-physician staff.

Inappropriate Assistance to Remote Facilities

We did not substantiate allegations of inappropriate ED physician assistance to remote CLC and clinics (sites).

The system has a CLC and eight remote outpatient clinics. Allegations regarding inappropriate demands on the ED physicians involved requests for physician orders (for patient condition changes) and pronouncing a CLC patient’s death over the phone.

Telephone orders (those conveyed verbally by a physician over the telephone to a nurse who records the orders in the computerized patient record system [CPRS]) may be necessary during an emergent or urgent situation when the physician does not have ready access to CPRS or is absent from the facility.¹⁶ The remote assistance through the provision of telephone orders to address patient needs, especially during hours when local physicians are not readily available, is appropriate and addresses continued care needs.

The facility’s medical staff bylaws require that patients be pronounced dead by a licensed physician or a specially trained CLC RN. We did not substantiate the allegation that a

¹⁵ Facility Memorandum 136-08, *Inter-facility Transfer Policy*, August 21, 2009.

¹⁶ Facility Memorandum PS-14, *Verbal and Telephone Orders*, March 4, 2008.

clinician pronounced a CLC patient's death over the telephone because the complainant did not provide the patient's name or the date the incident occurred. Further, staff interviews and document reviews did not identify any evidence to support this allegation.

Conclusions

We concluded that the four identified patients had received appropriate care. We substantiated allegations of inadequate triage practices, poor communication, and inappropriate referrals of patients from the PCCs. We did not substantiate allegations of a delayed admission for Patient 1, a poor orthopedic surgery response for Patient 4, and poor gynecology and trauma surgery response to ED consultation requests. Because timely response by orthopedic surgery was identified by facility managers and staff as an ongoing concern, we recommended that managers should monitor timeliness of orthopedic consultations for ED patients and take actions as needed.

We did not substantiate allegations of inadequate staffing and inappropriate scheduling of physicians or of excessive verbal and physical assaults on staff with a lack of VA police presence or intervention. However, we received complaints related to poor communication and a lack of teamwork in the ED and concluded training to help foster a work environment in the ED that encourages open communication, cooperation, and respect could be helpful.

We did not substantiate allegations of excessive paperwork for inter-facility transfers or inappropriate physician assistance to the remote CLC. However, we identified an improvement opportunity with the inter-facility transfer process.

Recommendations

Recommendation 1. We recommended that the Facility Director ensures that RN triage practices are consistently performed and training is completed.

Recommendation 2. We recommended that the Facility Director ensures that communication and referral processes between the ED and PCCs include more effective data sharing and joint efforts to improve patient flow.

Recommendation 3. We recommended that the Facility Director ensures that ED managers monitor orthopedic surgery consultation timeliness of response to ED consultation requests.

Recommendation 4. We recommended that the Facility Director ensures that ED managers and staff undergo training and other steps that would help promote a positive work environment in the ED.

Recommendation 5. We recommended that the Facility Director reviews the current inter-facility transfer process and provide appropriate administrative support with paperwork requirements.

Comments

The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable action plans. (See Appendixes A and B, pages 11–14 for the full text of their comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: November 14, 2011

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Healthcare Inspection – ED Quality of Care, Safety, and Management Issues, Dallas VA Medical Center, Dallas, TX**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Thru: Director, VHA Management Review Service (10A4A4)

1. Thank you for allowing me to respond to this Healthcare Inspection regarding the Quality of Care, Safety and Management Issues provided in the Emergency Department at the Dallas VA Medical Center, Dallas TX.

2. I concur with the recommendation and have ensured that an action plan has been developed.

3. If you have further questions regarding this inspection, please contact Denise B. Elliott, VISN 17 HSS at 817-385-3734.

(original signed by:)

Lawrence A. Biro

Director, VA Heart of Texas Health Care Network (10N17)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 8, 2011

From: Director, VA North Texas Health Care System (549/00)

Subject: **Healthcare Inspection – ED Quality of Care, Safety, and Management Issues, Dallas VA Medical Center, Dallas, TX**

To: Director, VA Heart of Texas Health Care Network (10N17)

We appreciate the opportunity to review the draft report of the Emergency Department Quality of Care, Safety, and Management Issues review completed May 11-12, 2011 for the VA North Texas Health Care System in Dallas, Texas.

Attached you will find actions for each recommendation. Several of these actions have already been completed.

We would like to extend our appreciation to the Office of Inspector General Team who was consultative, professional and provided excellent feedback to our staff. We appreciate their thorough review and the opportunity to further improve the quality care we provide to our Veterans every day.

(original signed by:)

Mr. Jeffery L. Milligan

Director, VA North Texas Health Care System (549/00)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendation

Recommendation 1. We recommended that the Facility Director ensures that RN triage practices are consistently performed and that training is completed.

Concur **Target Completion Date:** February 1, 2012

Facility's Response:

Triage nurses consistently use an ESI triage algorithm. Based upon a recent needs assessment for triage education, an education plan is being drafted for education of all nurses who are involved in triage.

Status: Open

Recommendation 2. We recommended that the Facility Director ensures that communication and referral processes between the ED and PCCs include more effective sharing of data and joint efforts to improve patient flow.

Concur **Target Completion Date:** July 15, 2011

Facility's Response:

The Deputy Chief of Staff met with the Chiefs of Medical Service and Ambulatory Care Service and worked with them to keep the appropriate patients in the clinics, and not send them to the ED. The number of inappropriate referrals to the ED from PCC has decreased by at least 50%. Patients who present to the ED with indication for lower level of care are referred to the clinics for walk-in appointments.

Status: Closed

Recommendation 3. We recommended that the Facility Director ensures that ED managers monitor orthopedic surgery timeliness of response to ED consultation requests.

Concur **Target Completion Date:** December 1, 2011

Facility's Response:

The ED manager will ensure a daily audit of orthopedic surgery timeliness of response to ED consultation requests. A review of the data will occur with the Chief of Medical Service weekly. Any untimely responses will be further reviewed to identify any barriers to providing care appropriately.

Status: Open

Recommendation 4. We recommended that the Facility Director ensures that ED managers and staff undergo training that would help promote a positive work environment in the ED.

Concur **Target Completion Date:** November 1, 2011

Facility's Response:

Staff meetings are being held regularly in the ED with a focus on cooperation, customer service, and professionalism. Shared Governance meetings occur Fridays, and the Chief of Medical Service meets with ED leadership weekly to review any issues that may have arisen. Employees also participate in Patient Centered Care (Planetree) initiatives.

Status: Closed

Recommendation 5. We recommended that the Facility Director reviews the current inter-facility transfer process and provide appropriate administrative support with paperwork requirements.

Concur **Target Completion Date:** Nov. 1, 2011

Facility's Response:

During the night shift, the AOD completes the copying of the four extra documents copied for transfer out of the ED. The Charge Nurse of the ED completes the copying of the extra documents during day shift.

Status: Closed

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Daisy Arugay Michael Shepherd, MD Kathleen Shimoda Mary Toy

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